MADRAS MEDICAL COLLEGE AND

RESEARCH INSTITUTE

CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements
For

DPM Final Examination

March 2010

By

Dr. SARITHA.D

INSTITUTE OF MENTAL HEALTH, KILPAUK
CHENNAI – 600 01

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BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by **Dr. SARITHA.D** in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period June 2008 - March 2010.

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I thank the Director, Institute of Mental Health, Chennai - 600 010, who has given his kind permission to interview the patients for preparing this case record.

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I would also like to thank the patients and their family members who cooperated for undergoing the tests and gave the necessary details required.

INDEX

PATIENT 1

Name	:	Mr. C
Age	:	25 years
Sex	:	Male
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	IX Standard
Socio economic	:	LSES
Informants	:	Father
Information	:	Reliable, Adequate and consistent

PRESENTING COMPLAINTS

Talking excessively

Irritability

Abusive, assaultive — 5 weeks

Sleep disturbance

Talking to self

Insidious onset, progressive course, II episode

HSITORY OF PRESENT ILLNESS

According to the informant, 5week back, patient was noticed by his mother to be

awake frequently during the night. He would be going through the religious books. Gradually he was observed to be sleeping less and spending long hours with his books. He would turn irritable if his mother asked him to rest.

He would disturb his mother during night and insist that she listen to his plans of making a new business. At times he would abuse, assault his mother especially if she asked him to stop talking. He would start singing suggestive songs and dancing whenever he saw a girl passing by for which he was frequently warned. He would talk about past happenings, about how his friends cheated him and were jealous of him, continuously creating problems so that his plans were spoiled.

He would be seen sitting on bed, talking as though he were speaking to somebody in front of him.

No history of hearing voices, suicidal ideas. No history of substance abuse, head injury or fits.

PAST HISTORY

h/o similar illness in the past 1 year back. He was diagnosed as manic episode and he was treated with T.Haloperidol 1.5 mg,T.Sodium valproate 200 mg three times a day for 1 month. he attained premorbid level of functioning after taking medications of 1 month

FAMILY HISTORY

He is born of non consanguineous marriage. Father is an alcoholic. He is the first of three siblings, two younger brothers are alive and healthy.

No h/o similar illness.

PERSONAL HISTORY

Full term normal delivery

Milestones normal

Studied upto IX standard

Goes for part time job at private bank

Unmarried

No history of substance abuse

PREMORBID PERSONALITY

Extrovert, sociable, cheerful

Responsible, hardworking

PHYSICAL EXAMINATION

Conscious, ambulant

Afebrile

Not anemic, No pedal edema

No external injuries

Pulse – 80/min

BP- 120/90 mm Hg

CVS- S1, S2 heard,

RS – NVBS heard.

Abdomen – soft, nontender, No organomegaly

CNS- Clinically normal Funds- normal

MENTAL STATUS EXAMINATION

General Appearance and Behavior: Conscious, ambulant, in touch with surroundings, co-operative and disturbed by external cues. Hair not combed. Unshaved. Rapport established. No mannerisms, tics.

Psychomotor activity: Increased. Kept getting up from the chair often.

Talk: Quantum, tone, rate increased.

Mood: (s) happy and jolly

(o) Elated, Range and reactivity preserved.

Thought: Form: Flight of ideas

Stream: Increased

Content: Delusions of grandiosity

Referential ideas

Perception: No elicitable hallucinations.

COGNITIVE FUNCTIONS

Oriented to time, place and person

Attention aroused

Concentration ill sustained

Memory- immediate, recent and remote – intact

Abstract thinking intact

Judgement to test situation intact

Insight: grade I (Denies illness)

DIAGNOSTIC FORMULATION:

Mr. C 25 years old, unmarried male, presenting with second episode of irritable Mood, restlessness, talking excessively, sleep disturbance and tall claims, mental Status examination reveals increased psychomotor activity, pressure of speech, Flight of ideas, grandiose delusions, referential ideas, elated mood, impaired Concentration and grade I insight.

PROVISIONAL DIAGNOSIS

F 31.2 Bipolar Affective Disorder, current episode mania with psychotic features.

PSYCHOLOGICAL ASSESSMENT

Mr. C was taken up for psychological testing to assess nature of his present disturbance, psychosocial, interpersonal difficulties and to aid in diagnosis.

TESTS ADMINISTERED

- Eysenck personality Questionnaire (EPQ), was used to assess the different dimensions of his personality.
- Sentence Completion test (SCT), was used to elaborate on his attitude towards family, parents, and his interpersonal relationships.
- Thematic Apperception Test (TAT), a projective test of personality used to assess his interpersonal relationship, goal and conflicts.
- Rorschach Inkblot Test, a projective test of personality used to assess his personality structure and diagnosis
- Young Mania Rating Scale (YMRS), was used to rate intensity of various symptoms he was exhibiting.

BEHAVIOURAL OBSERVATION:

The patient had to be repeatedly asked to sit as he was preparing to leave. He said that he was alright and had many jobs to complete. He often looked around with suspicion and promised to elaborate on a discovery he had made, later to the interviewer.

TEST RESULTS

EPQ shows that he is an extrovert with significant scores on neuroticism also. He also scored significantly on the lie scale indicating that he has certain internal conflicts.

On the **sentence completion test**, he has positive attitude towards his family members and expressed his wish to stay with his mother throughout his life. He considers heterosexual relationships enjoyable and wanted to have contact with females in future. He expressed confidence that he could overcome misfortune in life. He perceives himself as a highly capable person and promises that his discoveries would be extremely useful to mankind in future. He has a tendency to associate the responses of one sentence with the next.

On **TAT**, patient's descriptions were poetic. Significant clang associations and rhyming tendencies were noted. He projected himself as the hero in the stories and also of his grandiose abilities. Some of his themes were aggressive and others reflected his optimism. The descriptions are of good length.

On **Rorschach**, the number of responses was noted to be excessive. He concentrates more on minute details, and his touch with reality is impaired as shown by reduced popular responses. Content analysis shows aggressive and impulsive nature.

His scores on **YMRS** show that he is hyper verbal, elated, hyperactive, hypersexual and irritable. He has significant sleep disturbance, and has grandiose ideas. He has poor judgement, is argumentative and elaborates upon new plans and projects that comes through in his mind. His dressing sense and self care is within acceptable limits and he has no insight into his illness. On the whole he has severe manic symptoms.

SUMMARY

He has predominant manic symptoms as seen on various tests indicating that the patient is suffering from mood disorder currently mania.

FINAL DIAGNOSIS

F 31.2 Bipolar Affective Disorder, current episode Mania with Psychotic features.

MANAGEMENT

Pharmacological:

Patient is on T. Olanzapine $_{5\ mg}$ 1-0-1

T. Clonazepam $_{0.5\ mg}$ 0-0-1

T. Sodium Valproate $_{200\ mg}$ 1-1-1

Psychological: Once the patient becomes quiet, counseling should be done regarding the nature of the disorder and the need to adhere to medication schedules. Insight should be promoted. Family counseling regarding follow up and support to the patient is essential.

PATIENT 2

Name	:	Mrs. E
Age	:	31 years
Sex	:	female
Occupation	:	Unemployed
Religion	:	Christian
Education	:	XII Standard
Socio economic	:	LSES
Informants	:	Parents & Sisters
Information	:	Reliable, Adequate and consistent

REASON FOR CONSULTAION:

1. Withdrawn from family members- 2 years
2. Suspiciousness towards husbands fidelity – 2 yrs
3. Suspiciousness that somebody plan to harm her -2 yrs
4. talking to self - 1yrs
5. Sleeplessness- 6 month

HISTORY OF PRESNET ILLNESS:

Mrs. E, got married 3 yrs ago, she was normal upto 1 yr after marriage, then husband noticed that she did not mingle with family members and prefered to stay alone. Initially she suspected her husband that her husband had physical relationship with many

women, then she suspected that her husband had physical relationship with her sister. and she complained to her mother that her neighbours were always talking about her, They planned to harm her. She quarreled with her neighbours and assaulted them
.
2 weeks later, she suspected that her family members mixed poison in her food, gradually she began to talk alone; not do her routine house hold activities .she had decreased appetite. She did not take food in adequate amount. She did not take care of her personal hygiene as before. She took bath and brushed her on compulsion by her mother

No H/O Repetitive thoughts and acts

No H/O head injury /seizures

No H/O suicidal ideation /attempt.

PAST HISTORY

Nil Significant.

FAMILY HISTORY

Father separated from mother -20 yrs ago. H/O major mental illness in her elder sister.

PERSONAL HISTORY

Full term normal delivery

Normal milestones

Above average in studies

PREMORBID PERSONALITY

Well adjusted, longing for love

PHYSICAL EXAMINATION

General examination WNL

CVS- S1, S2 heard

RS-NVBS heard

Abdomen – soft, nontender, no organomegaly

CNS- clinically normal.

BP- 110/70 mm Hg

Pulse – 80/min

MENTAL STATUS EXAMINATION:

General Appearance: patient was alert, ambulant, dressed well, gaze avoidance observed,

Rapport was established with difficulty

Psychomotor activity normal

Talk- decreased productivity, relevant and coherent

Affect – restricted affect

Thought- Delusion of infidelity and Delusion of persecution

Perception- III person auditory hallucinations. Commenting male voices

COGNITIVE FUNCTIONS

Attention aroused but poorly sustained

Memory immediate, recent and remote intact

General information average

Calculation average

Poor abstract ability

INVESTIGATIONS

Blood WNL

CT scan NAD

DIAGNOSTIC FORMULATION

31Years old married female with 2 yrs h/o poor interaction, suspiciousness towards husbands fidelity, suspiciousness that somebody planned to harm her, talking to Self, hostility towards family members, MSE revealing decreased speech productivity, Gaze avoidance, constricted affect, delusions of Persecution, III person auditory hallucinations commenting type.

DIAGNOSIS

F20.0 PARANOID SCHIZOPHERNIA

PSYCHOLOGICAL ASSESMENT

Mrs. E is provisionally as a case of paranoid schizophrenia. She is assessed for her personality, psychology and confirmation of diagnosis.

TESTS ADMINSTERED AND THEIR RATIONALE:

• Symptom Sign Inventory: It is used to arrive at a diagnosis by rating her symptom on various diagnostic categories.

• Sentence Completion test: It is a semi projective test used to assess her attitudes toward

her self, family, friends, colleagues and superiors. It is also used to assess her attitudes towards future aims and goals in life and the possible guilt in his life.

• Thematic Apperception test: It is a structured projective test to assess her interaction, conflicts and outlook toward future.

• It is an unstructured projective test used to assess her personality and to arrive at a diagnosis

BEHAVIOURAL OBSERVATION:

She is cooperative for testing but is not very spontaneous or enthusiastic. She looks concerned in between and thinks for a long time in- between, she has an indifferent mood must of the time.

She has elevated scores on the dimension of paranoia and schizophrenia. Some of the paranoid items given by her are that of strange and unique experiences, getting confused, and confusion over thinking.

She has negative feelings towards his parents and friends as seen from sentence completion test. She feels she is isolated in the world and no one cares for her wellbeing. She also feels overwhelmed by the hostility expressed by the world around her.

Thematic Apperception Test- her stories on TAT are brief and appear to be ordinary contents reveal themes of poverty, vengeance, interpersonal conflicts: aggression and hostility. Feeling of loneliness is expressed here and there.

Rorschach reveals that she has no clear cut concepts and clear boundaries to her responses. Poor recall ability of her responses was noted. Her popular and human responses show low human interaction and his poor touch with reality. Contents also

reveal hostility and loneliness, poor ego strength and negative perception of life.

SUMMARY

- Definitive psychotic perception in Rorschach
- Elevated scores on paranoia, schizophrenia on SSI
- Themes of conflicts, aggression, hostility, vengeance in TAT

Findings favour a diagnosis of paranoid Schizophrenia

FINAL DIAGNOSIS

F20.0 paranoid Schizophrenia

MANAGEMENT

PHARMACOLOGICAL- Atypical antipsychotic- Resperidone 4 mg/day

PSYCHOTHERAPHY- Distraction techniques for authority hallucinations

OCCUPATIONAL THERAPY

PATIENT 3

Name	:	Mr. D
Age	:	42 yrs
Sex	:	Male
Marital status	:	Married
Occupation	:	Auto driver
Education	:	Uneducated
Socio economic status	:	LSES
Informants	:	Wife
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

Consumption of Alcohol	- past 21 yrs
Increased frequency and quantity	- past 5 yrs
Sleep disturbance	- 1 month

HISTORY OF PRESENT ILLNESS:

The patient who was brought by his wife, he started to use alcohol 21

yrs ago along with his friends for pleasure, he gradually increases frequency as well as quantity over the time.

For the past 5 yrs he used to have almost daily and start to have early in the morning, he was an auto driver, for his alcoholic behavior he spent most of the money for alcohol and frequent absent in work so his productivity decreased.

Because of that he had frequent interpersonal problem with wife. Before 1 week for the welfare of the family and concern with his physical condition he quit alcohol since he had sleeplessness.

No H/O withdrawal Seizures | Suicide Attempt

No H/O head injury | Seizures | hemetemesis | Malena

PAST HISTORY:

History of jaundice before 10 yrs

No history of head injury, seizures or fever.

No history of Hypertension or Diabetes Mellitus.

No history of substance use.

FAMILY HISTORY:

Family h/o Alcoholism – his father and 2 elder brothers.

PERSONAL HISTORY:

Early childhood history was not known.

Born of consanguineous marriage.

Married at the age of 25 yrs.

Living with 1 daughter and 3 sons.

PREMORBID PERSONALITY:

Adjustable and Easy going.

Tolerant to criticism, responsible.

He handled money and financial matters without others' help.

PHYSICAL EXAMINATION:

Thin built, not anemic, icterus, no pedal edema.

Pulse – 68/min

BP – 120/80 mm Hg

CVS – S1, S2 heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

MENTAL STATUS EXAMINATION:

General Appearance and Behavior: Conscious, ambulant, Rapport established, co operative for Interview, neatly dressed, tremor on outstretched hands.

Psychomotor Activity – normal.

Talk - communicable, tone, quantum and reaction time – normal.

Mood – (s) feels good

(o) Euthymic

Thought – No delusions.

Perception – No perceptual disturbances.

COGNITIVE FUNCTIONS:

Conscious, oriented to time and place and person.

Attention aroused and sustained.

Memory – recent, remote and immediate memory are intact.

Intelligence – normal

Insight – True emotional insight.

PROVISIONAL DIAGNOSIS:

F10- Mental and Behavioral disorder due to an Alcohol.

PSYCHOLOGICAL ASSESSMENT:

Mr. D, who was provisionally diagnosed as a case of Mental and behavioral disorder due to an alcohol and he is taken up for psychological testing to establish the diagnosis and to assess the motivation and risk for relapse.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **CAGE questionnaire –** It is a screening test to identify the alcoholic abuse.
2. **Michigan alcohol screening test (MAST) –** Used to assess alcohol use and Alcohol related disabilities.
3. **Inventory of drug taking situations (IDTS) –** Used to assess situations which

trigger heavy drinking and used to better understand relapse episodes in Individuals.

BEHAVIORAL OBSERVATION:

The patient is co operative and discloses information enthusiastically.

TEST RESULTS:

In CAGE questionnaire reveals that he was dependant on alcohol, guilt about his drinking, easily annoyed by people, unable to cut down his drinking.

In MAST reveals that he had many alcoholic response and diagnosed as Alcoholism.

On IDTS he drank heavily when he was depressed about things in general, he felt shaky, sick or nervous and when he had trouble sleeping and to relieve somatic pain.

SUMMARY:

He is suffered from alcohol dependence syndrome, and has good motivation.

FINAL DIAGNOSIS:

F10. Mental and Behavioural Disorder due to use of Alcohol.

F1x.2 Dependence syndrome

.20 Currently abstinent.

MANAGEMENT:

PHARMACOLOGICAL:

Treatment the medical illness

Detoxification

Benzo diazepines – diazepam 5 mg HS

FAMILY COUNSELLING:

Family counseling to provide awareness to the family members about the risk of the relapse, family members must learn not to protect the patient from the problem caused by alcohol. Otherwise the patient may not be able to gather the energy and motivation necessary to stop the alcohol.

Importance of follow-up is stressed o monitor the condition of patient and to help the family members in dealing with the patient adequately.

REHABILITATION:

Continued effort to increase and maintain high levels of motivation for Abstinence.

Work to help the patient readjust to a lifestyle free of alcohol.

Relapse prevention.

SELF HELP GROUPS:

Members of AA have help available 24 hours a day, associate with a sober peer group, learn that it is possible participate in the social functions without drinking, and Are given a model of recovery by observing the accomplishments of sober members

of the groups.

PATIENT 4

Name	:	Mrs. H
Age	:	28 yrs
Sex	:	Female
Religion	:	Hindu
Marital status	:	Married
Occupation	:	Auto driver
Education	:	Uneducated
Socio economic	:	LSES
Informants	:	Husband
Information	:	Reliable.

REASONS FOR CONSULTATION:

1. Aggressive towards family members- 2 months
2. Inappropriate cry- 2 months

HISTORY OF PRESENT ILLNESS:

Patient was married 5 yrs ago, since marriage itself she didn't do any basic routine activities, initially husband tried to train her but he was unable to do so, she

always prefered to simply sit in home. gradually she was able to do simple activities like cleaning house but that too not completely,.

She was not interested in her personal hygiene, she could do only after repeated instruction by husband, for past 2 months she was aggressive and threw the things in home and inappropriately crying most of the time .

No H/O Head injury / loc

No H/O Seizures

No H/O Fever before the onset of illness

No H/O Suicidal ideation / attempt

PAST HISTORY

No H/O Seizure episode

FAMILY HISTORY

Born of consanguineous parents

No H/o seizures, MR in family

Married and have 2 children

PHYSICAL EXAMINATION:

General condition fair

Pallor

Pulse- 80/min

BP-110/76

CVS- S1, S2 heard

RS- NVBS heard

Abdomen – soft, nontender

CNS- No FND, No Neurocutaneous markers

Fundus – NAD

MENTAL STATUS EXAMINATION

Anxious, oriented, in touch with surroundings

Dressed fairly, well kempt

Unsteadiness of gait+

Drooling of saliva+

Poor gaze contact

Rapport was difficult to establish

She is fidgety and restless.

Incessant cry +

Increased psychomotor activity

Speech – utters 2 or 3 words

Silly affect

COGNITIVE FUNCTIONS

Attention aroused but not sustained

Oriented to place, person

General information- poor

PROVISIONAL DIAGNOSIS

F72 Mental Retardation – Moderate

PHYSICHLOGICAL ASSESMENT

Mrs. H is assessed for her intellectual functions and social function with the following tests.

1. Binet Kamat Test for General Mental Ability- it is test of intelligence and to rest the baseline intellectual abilities
2. Vineland Social Maturity Scale- Used to assess her social maturity level
3. Behavioral Rating Scale.

BEHAVIOURAL OBSERVATION:

She was not very cooperative for testing and had less interest in the test situation. Patient was not very attentive and was not able to concentrate for most of the tests. Her Psychomotor activity was raised and she was fidgety.

TEST RESULTS:

Her gestalt functions and concept formation of size, shape and form were corresponding to the 10 yrs of age. She was able to carry out simple commands with difficulty. Her functioning is below 12 years as seen from Binet Kamat test.

Her social functioning is about 12 years as rated from Vineland Social maturity scale. Her husband reports that she is functioning at the age of 12 yrs in self help, eating,

dressing, occupation and at the level of 10 years in communication, locomotion and socialization.

On behaviour rating scale she scored highly on many items in violent behaviour, destructive behaviour and rebellion and hyperactive behaviour.

SUMMARY

She was poor intellectual functioning. Her IQ of 36 places her in moderate mental retardation with behavioral problems. She needs help from members to take adequate car of her.

FINAL DIAGNOSIS:

F 72 Mental Retardation – Moderate.

MANAGEMENT:

1 Behaviour modification by shaping, prompting

2 Rehabilitation and special training. The training should help her to acquire basic life skills and possibly some amount of independence in day chores like brushing, putting clothes etc.

3 Pharmacotherapy- is reserved only in case of serve aggression, violence etc, Carbamazepine would be considered the best.

PATIENT 5

Name	:	Mr. K
Age	:	22 yrs.
Sex	:	Male
Religion	:	Hindu
Education	:	Studying B.Sc
Socio economic	:	LSES
Informants	:	Father
Information	:	Reliable, Adequate and consistent

PRESENTING COMPLAINTS

1. Repeated doubts about his activities
2. Fear of contamination and frequent elaborate washing
3. Declining academic performance

HISTORY OF PRESENT ILLNESS:

As per the patient, he started having his problems insidiously, beginning with doubts about simple activities like locking a door, counting money, etc. He had to check and recheck to satisfy himself. This progressed to irrational thoughts that his hand would be contaminated and subsequent repeating washing of his hand.

He recognized these thoughts as his own and irrational unwanted ones, but he could not control the anxiety associated with this. But his anxiety was not associated with palpitations, tremor, sweating and difficulty in breathing. He took more time to bathe and wash, he was unable to concentrate any work and produced significant impairment in his studies and daily activities.

No h/o head injury, seizures, talking to self, hearing voices.

No h/o suicidal attempt, Ideation

PAST HISTORY:

Nil significant

FAMILY HISTORY:

Born of non consanguineous marriage.

No family history of similar illness.

PERSONAL HISTORY:

Developmental milestones normal.

Student currently in his 2nd year of degree.

PREMORBID PERSONALITY:

Quiet, unassuming, shy, had many friends, religious, conscientious and a perfectionist.

PHYSICAL XAMINATION:

General examination WNL

CVS- S1, S2 heard,

RS – NVBS heard.

Abdomen – soft, nontender, No organomegaly

CNS- Clinically normal Funds- normal

BP- 110/70 mm Kg

Pulse-80/min

MENTAL STATUS EXAMINATION:

General Appearance: Cooperative, attentive, well kempt

Psychomotor activity normal

Talk – relevant and coherent. Quantum Tone Rate normal

Mood (s) Anxious

(o) Anxious

Thought from, stream normal

Obsessive thoughts about contamination

COGNITIVE FUNCTIONS

Oriented to time, Place and person

Attention arousable, concentration well sustained

Memory- immediate, recent and remote – intact

General fund of information adequate

Abstract thinking intact

Judgment to test situation intact

Grade V insight

DIAGNOSTIC FORMAULATION

22 yrs male presenting with complaints of frequent washing of his hand and fear of contamination, unpleasant and intrusive thoughts, MSE revealing anxious affect, obsessive thoughts and compulsive acts

.

PROVISIONAL DIAGNOSIS:

F 42.2 obsessive compulsive disorder- Mixed obsessional thoughts and acts.

PSYCHOLOGICAL ASSESMENT

Mr. K. clinically diagnosed as a case of OCD is taken up for psychological assessment to Assess his symptom patterns. Severity of illness and for personality.

TEST ADMINSTERED AND THEIR RATIONABLE:

1 Eysenck Personality inventory: is used to assess his personality

2 Multiphasic Questionnaire – is also used to access personality and possible psychotic symptoms.

3 Sentence Completion Test : was used to elaborate on his attitude towards self, family, college, parents, and his interpersonal relationships and also to assess his fears, aims and goals.

4 Rorschach test, a projective test of personality used to asses his personality structure and diagnosis.

5 Thematic Apperception Test,: a projective test of personality used to assess

his interpersonal relationship, goals and conflicts.

6 Hamilton Anxiety rating Scale- to assess the degree of anxiety

7 Yale- Brown obsessive compulsive scale- for rating the severity obsessions and compulsions.

BEHAVIOURAL OBSERVATION:

Very good at expressing his problems, rapport could be established easily.

TEST RESULTS

Esyenck personality inventory: showed that he is an ambivert person with severe degree of neuroticism. Low lie scores indicate that he is straight

Multi Questionnaire: His scores on MPQ indicate severe degree of neuroticism with low psychoticism and moderate extroversion.

Thematic Apperception test: His stories are productive, imaginative and projective of his childhood experience of neglect. He is also neurotic with fear of darkness, loneliness.

Rorschach test he is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. He has adequate ego strength inspite of neurotic fears which favors psychotherapeutic interventions.

Y- BOCS and HAM-A- reveal mixed symptoms of obsessions and compulsions with features of anxiety.

SUMMARY:

He scored high on various neurotic dimensions on personality indicating he is highly neurotic in his feelings and reactions to the environment with which we can diagnose him as a case of mixed neurosis with obsessive symptoms.

FINAL DIAGNOSIS

F42.2 obsessive compulsive disorder, mixed obsessional thoughts and acts.

MANAGEMENT

PHARMACOTHERAPHY

SSRI- Fluoxetine 40mg OD

PSYCHOTHERAPY

Cognitive behaviour therapy- to manage his irrational beliefs and to modify the subsequent unwanted behaviour. Focus on the obsessions.

Exposure and response prevention- to manage the compulsions

Thought stopping – to control the obsessive thoughts.